DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445406	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	07/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE OF RUTHERFORD	901 COUNTY FARM RD MURFREESBORO, TN 37127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the smoke and fire wall barrier. The findings included: 1. Observation on 7/15/2015 at 9:33 AM, revealed unapproved fire stop material (flammable foam) in the following fire wall locations: a. mechanical room near the kitchen. b. Mechanical room in G-Hallway. c. Mechanical room in the service hallway. d. In the interstitial area in the clean laundry room (wall next to F&G Dining room). e. In the interstitial area in the service hallway in the clean room (where the sweeper is stored). f. In the interstitial area in the service hallway above the clean laundry room door. g. Behind the commercial dryers on the ceiling. National Fire Protection Association (NFPA) 101, 8.2.3.2.4, 2000 Edition. 2. Observation on 7/15/2015 at 9:51 AM, revealed	K 025	1. Unapproved flammable foam was removed and approved fire stop was placed in the following areas by maintenance personnel: a. 8/17/15 - Mechanical room near the kitchen; b. 8/14/15 - Mechanical room in G Hallway; c. 8/14/15 - Mechanical room in the service hall; d. 8/14/15 - Interstitial area in the clean laundry room next to F&G dining room; e. 8/14/15 - Interstitial area in the service hallway clean room where sweeper is stored; f. 8/14/15 - Interstitial area in the service hallway above the clean laundry room door & g. 8/17/15 - Ceiling behind the commercial dryers. 8/14-18/15 - A facility wide audit was performed with additional areas of foam being discovered. Those areas have been addressed and corrected by the maintenance department. 2. The smoke wall was sealed with approved smoke resistant material in the following areas by maintenance personnel: a. 8/17/15 - Interstitial area above room J104 & b. 8/14/15 - Room F-12. 8/14-18/15 - A facility wide audit was performed with additional areas of foam being discovered. Those areas have been addressed and corrected by the maintenance department. QA Walking audits are conducted monthly by the Maintenance Department staff to evaluate the integrity of ceiling tiles, and wall damage as part of the on-going Preventative Maintenance Program. Work orders generated by staff will be reviewed by the Maintenance Director and addressed when received. Status reports will be reviewed in the Daily Morning QA Managers Meeting. Audit reports will be reviewed in the monthly QA Meeting.	8/19/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administator	8/21/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 the smoke wall not sealed with approved smoke resistant material (flammable foam) in the following locations: a. In the interstitial area above room J104. b. In room F12. NFPA 101, 8.3.6.1, 2000 Edition. These findings were verified by the maintenance director and acknowledged by the director of nursing during the exit conference on 7/14/2015.	K 025		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the sprinkler system. The findings included: 1. Observation on 7/14/2015 at 9:14 AM, revealed an escutcheon plate missing in the closet in room K106. NFPA 13, 3-2.7, 1999 Edition. 2. Observation on 7/14/2015 at 9:15 AM, revealed storage within 18 inches of a sprinkler in the closet of room K105. NFPA 13, 5.5.6, 1999 Edition. 3. Observation on 7/14/2015 at 9:25 AM, revealed the sprinklers loaded with foreign material in the following locations:	K 062	Sprinkler system maintenance was completed in the following areas by maintenance personnel/qualified vendors: 1. 8/13/15 - K-106 Escutcheon ring in the closet replaced; 8/13-17/15 - A facility wide audit by the maintenance department was performed with no other escutcheon plates found missing. 2. 8/13/15 - K105 - Storage within 18 inches of the sprinkler was moved. 8/13-17/15 - A facility wide audit by the maintenance department was performed and other instances have been corrected. 3. Sprinklers loaded with foreign material were cleaned or replaced: a. 8/13/15 - Hallway between J105 - J107; b. 8/13/15 - J101 (1 of 3); c. 8/13/15 - Dish washing area (1 of 2); d. 8/13/15 - Kitchen above the island sink area; e. 8/13/15 - Room G8 (1 of 2); f. 8/13/15 - Soiled laundry room. 8/13-17/15 - A facility wide audit was performed with additional sprinkler heads found and were cleared of foreign material by the maintenance department. 4. 8/28/15 - Sprinkler heads placed under the service hall canopy. 5. 8/28/15 - Corroded sprinklers (2 of 2) on the kitchen loading dock replaced.	8/28/15

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K 062	Continued From page 2 a. In the hallway between room J105 and J107 (1 sprinkler). b. Room J101 (1 out of 3). c. Dishwashing area (1 out of 2). d. One (1) sprinkler above the island sink area in the kitchen. e. Room G8 (1 out of 2). f. Soiled laundry room (2 out of 4). NFPA 25, 2.2.1.1, 1998 Edition. 4. Observation on 7/15/2015 at 10:22 AM, revealed combustible storage under a canopy with no sprinklers. Storage consisted of the following: four (4) yellow bins, two (2) gray bins and one big gray bin. NFPA 13, 5-13.8.2, 1998 Edition. 5. Observation on 7/15/2015 at 10:40 AM, revealed corroded sprinklers two (2) out of two (2) in the kitchen loading dock. NFPA 25, 2.2.1.1, 1998 Edition. These findings were verified by the maintenance director and acknowledged by the director of nursing during the exit conference on 7/14/2015.	K 062	QA Walking audits are conducted monthly by the Maintenance Department staff to evaluate the integrity of sprinkler system and heads as part of the on-going Preventative Maintenance Program. Work orders generated by staff will be reviewed by the Maintenance Director and addressed when received. Status reports will be reviewed in the Daily Morning QA Managers Meeting. Audit reports will be reviewed in the monthly QA Meeting.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the kitchen suppression system. The finding included: Observation of the kitchen on 7/14/2015 at 9:48	K 069	K069 7/16/15 - Placard identifying the use of the K type fire extinguisher as a secondary backup means to the automatic fire suppression system was posted near the portable k type fire extinguisher in the cooking area by the maintenance department. 7/16/15 - There is no other kitchen and no other portable K type extinguishers. QA Walking audits are conducted monthly by the Maintenance Department staff to audit the presence and status of all fire extinguishers as part of the on-going Preventative Maintenance Program. Corrections will be made immediately.	7/16/15

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K 069	Continued From page 3 AM, revealed there was no placard identifying the use of the K type fire extinguisher as a secondary backup means to the automatic fire suppression system. The placard shall be conspicuously placed near each portable K type fire extinguisher in the cooking area. NFPA 96, 7-2.1.1 (1998 Edition). This finding was verified by the maintenance director and acknowledged by the director of nursing during the exit conference on 7/14/2015.	K 069	Status reports will be reviewed in the Daily Morning Managers meeting. Audit reports will be reviewed in the monthly QA Meeting.	
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and document review, the	K 074	Facility will provide flame spread documentation for all hanging window shears. a. 8/14/15 - J113 Window shears washed, fire blocked, date tagged and documented by maintenance personnel/designee. b. 7/14/15 - Barber Shop Window shears washed, fire blocked, date tagged and documented by maintenance personnel/designee. c. 8/14/15 - Exam Room window shears washed, fire blocked, date tagged and documented by maintenance personnel/designee. 8/11-14/15 - A facility wide audit was performed with no other instances found by the maintenance department. QA Walking audits are conducted monthly by the Maintenance Department staff to audit the presence of any new materials to ensure they have been fire-blocked prior to placing in use and on-going as part of the Preventative Maintenance Program. Corrections will be made immediately. Status reports will be reviewed in the Daily Morning QA Managers Meeting. Audit reports will be reviewed in the monthly QA Meeting.	8/14/15

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K 074	Continued From page 4 facility failed to provide the flame spread documentation for hanging window shears. The finding included: Observation and document review on 7/14/2015 at 9:19 AM, revealed window shears hanging in the window with no tag to identify the flame spread. In addition no documentation that the window shears have been treated with a flame retardant material in the following rooms: a. Room J113. b. Barber shop. c. The exam room. This finding was verified by the maintenance director and acknowledged by the director of nursing during the exit conference on 7/14/2015.	K 074		
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the generator. The finding included:	K 144	8/28/15 - An emergency generator remote annunciator (audible & visual) was installed in the Kitchen/JK foyer to ensure it is in a continuously occupied area. 8/28/15 - Weekly generator checks are performed and logged by the maintenance department along with monthly load tests to ensure proper working order is maintained. The 2nd generator has a remote annunciator panel located at the F&G nurses station. QA Weekly and Monthly Generator tests will continue as part of the on-going Preventative Maintenance Program. Concerns will be investigation for correction immediately. Status reports will be reviewed in the Daily Morning QA Managers Meeting. Audit reports will be reviewed in the monthly QA Meeting.	8/28/15

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K 144	Continued From page 5 Based on observation and interview on 7/14/2015 at 11:48 AM, revealed the facility failed to ensure an emergency generator remote annunciator was provided in a continuously occupied area in the H through K hallway (newer part of the building which has a separate generator). Interview with maintenance assistant confirmed that the only emergency generator annunciator panel for H through K hallway is in the electrical room near the kitchen. NFPA 110, 3-5.6, 1996 Edition. This finding was verified by the maintenance director and acknowledged by the director of nursing during the exit conference on 7/14/2015.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the electrical system. The findings included: 1. Observation of resident room H103 on 7/14/2015 at 8:40 AM, revealed a surge protector plugged into a multi-plug adapter (maintenance assistance removed on site). S&C: 14-46-LSC. 2. Observation on 7/15/2015 at 10:23 AM, revealed back to back surge protector in use in G-Wing nurses station (maintenance assistant removed on site). S&C: 14-46-LSC. These finding were verified by the maintenance	K 147	Corrections have been made to the electrical system in the following areas: 1. 8/13/15 - H-103 - Assistance offered to provide electricity for all of resident 's items. Surge protector removed 7/14/15. 7/14-16/15 - A facility wide audit was performed and other instances were found and corrected by the maintenance department. 2. 8/13/15 - In-service to nurses related to guide-lines for use of surge protectors. Surge protector at the G Wing nursing station removed 7/14/15. 7/14-16/15 - A facility wide audit was performed and other instances were found and corrected by the maintenance department. QA Weekly and Monthly facility physical plant rounds will continue as part of the on-going Preventative Maintenance Program. When observed, surge protectors will be removed immediately. Use of surge protectors will be reviewed in monthly staff in-service. Status reports will be reviewed in the Daily Morning QA Managers Meeting. Audit reports will be reviewed in the monthly QA Meeting.	8/13/15

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K 147	Continued From page 6 director and acknowledge by the administrator during the exit conference on 7/14/2015.	K 147		